215 ILCS 180/20 Notice of Right to External Review

Sec. 20. Notice of right to external review.

(a) At the same time the health carrier sends written notice of a covered person's right to appeal a coverage decision upon an adverse determination or a final adverse determination, a health carrier shall notify a covered person, the covered person's authorized representative, if any, and a covered person's health care provider in writing of the covered person's right to request an external review as provided by this Act. The written notice required shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by an independent review organization not associated with us by submitting a written request for an external review to the Department of Insurance, Office of Consumer Health Information, 320 West Washington Street, 4th Floor, Springfield, Illinois, 62767.".

(a-5) The Department may prescribe the form and content of the notice required under this Section.

(b) In addition to the notice required in subsection (a), for a notice related to an adverse determination, the health carrier shall include a statement informing the covered person of all of the following:

(1) If the covered person has a medical condition where the timeframe for completion of (A) an expedited internal review of an appeal involving an adverse determination, (B) a final adverse determination, or (C) a standard external review as established in this Act, would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review.

(2) The covered person or the covered person's authorized representative may file an appeal under the health carrier's internal appeal process, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative 30 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a concurrent or prospective review request or 60 days following the date the covered person or the covered person's authorized representative files an appeal of an adverse determination that involves a retrospective review request with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, then the covered person or the covered person's authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process for purposes of this Act.

(3) If the covered person or the covered person's authorized representative filed a request for an expedited internal review of an adverse determination and has not received a decision on such request from the health carrier within 48 hours, except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, then the covered person or the covered person's authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process for the purposes of this Act.

(4) If an adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's health care provider certifies in writing that the recommended or requested

health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, then the covered person or the covered person's authorized representative may request an expedited external review at the same time the covered person or the covered person's authorized representative files a request for an expedited internal appeal involving an adverse determination. The independent review organization assigned to conduct the expedited external review shall determine whether the covered person is required to complete the expedited review of the appeal prior to conducting the expedited external review.

(c) In addition to the notice required in subsection (a), for a notice related to a final adverse determination, the health carrier shall include a statement informing the covered person of all of the following:

(1) if the covered person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, then the covered person or the covered person's authorized representative may file a request for an expedited external review; or

(2) if a final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, then the covered person, or the covered person's authorized representative, may request an expedited external review; or

(3) if a final adverse determination concerns a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, and the covered person's health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, then the covered person or the covered person's authorized representative may request an expedited external review.

(d) In addition to the information to be provided pursuant to subsections (a), (b), and (c) of this Section, the health carrier shall include a copy of the description of both the required standard and expedited external review procedures. The description shall highlight the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information, including any forms used to process an external review.

(e) As part of any forms provided under subsection (d) of this Section, the health carrier shall include an authorization form, or other document approved by the Director, by which the covered person, for purposes of conducting an external review under this Act, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that is pertinent to the external review, as provided in the Illinois Insurance Code.

(Source: P.A. 96-857, eff. 7-1-10; 97-574, eff. 8-26-11.)